Supreme Court, U. S.
FILED
JUN 23 1976
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 75-1691

PAUL I. GUEST, ET AL., APPELLANTS

v.

F. EMMETT FITZPATRICK, ET AL.

No. 75-1698

THE WILLIAMSPORT HOSPITAL, ET AL., APPELLANTS

v.

F. EMMETT FITZPATRICK, ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

MOTION TO AFFIRM

WILLIAM E. ZEITER
ROY K. MEILMAN
2100 The Fidelity Building
Philadelphia, Pennsylvania 19109
MICHAEL VON MOSCHZISKER
MARGARET ANDERSON
Office of the Attorney General
Eastern Regional Office
Room 206 State Office Building
Philadelphia, Pennsylvania 19130
BONNIE BRIGANCE LEADBETTER
Office of the District Attorney
2300 Centre Square West
Philadelphia, Pennsylvania 19102

Of Counsel:
MORGAN, LEWIS & BOCKIUS

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CONTENTS

	Page
Statement	2
The Blue Cross-Subscriber Contract	2
The Blue Cross-Hospital Contract	3
Transmutation of the Blue Cross-Hospital Contract into a Hospital Cost Containment Tool	3
Effect of the Unanticipated Abandonment of Member Hospital Status by the DVHC	5
Response of the Commonwealth of Pennsylvania	8
Argument	11
A. Background	11
The Magnitude of the Crisis Facing the Legislature was Great	11
Act No. 94 Establishes Hospitalization Rates on the Basis of an Open-Ended Formula, Not a Fixed Price	12
The Formula Incorporated by the Statute is the Medicare Formula Which Was Developed by the American Hospital Association	14
The Formula Incorporated by the Statute is Applicable Only to Hospitals Who Have Benefited Greatly from it in the Past	15
The Formula is a Matter of Policy, Not Constitutionality	16
Appellants Had No Actual Expectation of Receiving their List Prices for the Locked-In Hospitalization Services	18

PAGE

The Issues Involved Herein are Virtually Mooted by the Timing of the Instant Litigation 19

B. Legal Analysis 20

The Power of the General Assembly to Adopt the Statutory Reimbursement Formula is Clear 20

The Power of the General Assembly to Make the Reimbursement Rate Partly Provisional is Clear 23

The Power of the General Assembly to Apply the Formula to the Hiatus Period is Clear..... 25

All of Appellants' Arguments are Legal in Nature 26

CONCLUSION 28

Exhibit A—Opinion of Newcomber, *J.* in Frankford Hospital *v.* Blue Cross of Greater Philadelphia (C.A. No. 74-2281, E.D. Pa.) (June 8, 1976) 29

Exhibit B—Letter of July 8, 1975 from Frank H. Abbott, Esq., counsel for DVHC, to Hon. William A. Shephard, Insurance Commissioner of Pennsylvania (Ex. 29 to Taylor Affidavit)..... 51

Exhibit C—Documents relating to Accord and Satisfaction of Payments during Litigation (Exhibit C to Amended Complaint) 54

Table of Authorities

CASES:

Association of American Physicians and Surgeons *v.* Mathews, 46 L. Ed. 2d 299 (1975) 21

PAGE

Borland *v.* Bayonne Hospital, 300 A.2d 584, 122 N.J. Super. 387 (Ch. Div. 1973), *aff'd,* 344 A.2d 331, 136 N.J. Super. 60 (1975).....13, 23

Chase Securities Corp. *v.* Donaldson, 325 U.S. 304 (1945) 25

Clemons *v.* United States, 46 L. Ed. 2d 381 (1975) 21

Corum *v.* Beth Israel Medical Center, 359 F. Supp. 909 (S.D.N.Y. 1973) 17

Doctors Hospital *v.* Blue Cross of Greater Philadelphia, Civil Action No. 73-1057 (E.D. Pa. August 13, 1975), *aff'd per curiam,* No. 75-2166 (3d Cir. April 28, 1976) 3

El Paso *v.* Simmons, 379 U.S. 497 (1965)..... 26

Fleming *v.* Rhodes, 331 U.S. 100 (1947)..... 26

Frankford Hospital *v.* Blue Cross of Greater Philadelphia, Civil Action No. 74-2281 (E.D.Pa.) (June 8, 1976) 13

F.P.C. *v.* Hope Natural Gas Co., 320 U.S. 591 (1944) 12

Munn *v.* Illinois, 94 U.S. 113 (1877) 20

Murphy Nursing Home *v.* Rate Setting Commission, 305 N.E.2d 837 (Mass. 1973), *appeal dismissed,* 417 U.S. 962 (1974) 17, 21

Nebbia *v.* New York, 291 U.S. 502 (1934) 20

New Jersey Association of Independent Insurance Agents *v.* Hospital Service Plan of New Jersey, 343 A.2d 739, 68 N.J. 213 (1975) 13, 22

New Jersey Chapter Incorporated of the American Physical Therapy Association, Inc. *v.* Prudential Life Ins. Co., 502 F.2d 500 (D.C. Cir. 1974), *cert. denied,* 420 U.S. 1004 (1975) 22

Rastetter *v.* Weinberger, 419 U.S. 1098 (1975).... 21

Steelworkers *v.* United States, 361 U.S. 39 (1959).. 24

PAGE

Travelers Ins. Co. *v.* Blue Cross of Western Pa., 361 F. Supp. 774 (W.D.Pa. 1972), *aff'd* 481 F.2d 80 (3rd Cir. 1973), *cert. denied,* 414 U.S. 1093 (1974) 13, 22

Wilson *v.* New, 243 U.S. 332 (1917) 24

OTHER AUTHORITIES:

Executive Office of the President, Council on Wage and Price Stability, Staff Report on "The Problem of Rising Health Care Costs" (April 1976) . 11

C. Hochman, "The Supreme Court and the Constitutionality of Retroactive Legislation," 73 Harv. L. Rev. 692 (1960) 25, 26

STATUTES:

Non-profit Hospital Plan Act, Act of June 21, 1937, P.L. 1948, now codified at 40 Pa.C.S.A. §§ 6101-6127 4

Pennsylvania Consolidated Statutes Annotated

40 Pa.C.S.A. § 6103(a) 4

40 Pa.C.S.A. § 6121 4

40 Pa.C.S.A. § 6124(a) 4

40 Pa.C.S.A. § 6124(c), as added by the Act of August 2, 1975 (No. 94) .....*Passim*

67 Pa.C.S.A. § 6102 4

Purdons Pennsylvania Statutes Annotated

62 P.S. § 1003 4

71 P.S. § 755-2 4

PAGE

FEDERAL STATUTES:

Taft-Hartley Act

29 U.S.C. §§ 178-180 24

29 U.S.C. § 183(c), as added by Pub. L. No. 93-360, 88 Stat. 396 24

42 U.S.C. § 291 *et seq.* 17

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On Appeal from the United States District Court for the Eastern District of Pennsylvania

MOTION TO AFFIRM

Pursuant to Rule 16(1)(c) of the Rules of this Court, appellees move to affirm the judgment of the district court.

STATEMENT

Central to the instant health care delivery dispute are the patient on one side and the hospital on the other. As an intermediary between the two are hospital plan corporations, many of which are known as "Blue Cross" plans.

The Blue Cross-Subscriber Contract. Blue Cross plans were established by the hospital industry itself as a mechanism to insure against the costs of hospital service. A potential hospital patient enters into a subscription contract with a hospital plan corporation (hereinafter a "Blue Cross Plan"). Under the typical subscription agreement the Blue Cross Plan agrees to provide one of two alternative types of benefits:

(a) Under the more usual arrangement, the Plan will obtain hospital services for the subscriber in a so-called "member hospital". In some cases the subscriber must pay a relatively small portion of the hospital bill as coinsurance. In other cases the full hospital service is provided by the Plan, and no payment is made by the subscriber in connection with a spell of hospitalization. The benefit under this alternative is referred to as a "service benefit".

(b) Where the subscriber is admitted to a hospital which is not a "member hospital", the Plan merely makes a cash payment directly to the subscriber in whole or partial reimbursement of his or her cost of hospitalization. Typically, this payment will be much less (perhaps as much as 75% less) than the full hospital charge. The benefit under this alternative is referred to as an "indemnity benefit".[1]

The Blue Cross-Hospital Contract. There is no need for a Blue Cross Plan to have any contractual relationship with hospitals in a community in order to provide the indemnity benefit, which, as indicated above, is ordinarily paid directly to the patient-subscriber. To provide the usually more comprehensive service benefit, however, a second class of contract is necessary, *i.e.*, between the Blue Cross Plan and the hospitals in a community. It is of major significance to this litigation that historically almost all major hospitals in Pennsylvania have been member hospitals contracting with Blue Cross. Indeed, until the recent defection of the appellants in No. 75-1691 (the Delaware Valley Hospital Council-represented hospitals), litigation had arisen in exactly this direction, *i.e.* appellee Blue Cross of Greater Philadelphia has been made a defendant for allegedly improperly refusing to admit a hospital to the widely-desired status of member hospital.[2]

Transmutation of the Blue Cross-Hospital Contract into a Hospital Cost Containment Tool. The initial

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[1] Appellants in No. 75-1698 incorrectly state (J.S. pp. 18-19) that "[n]onmember hospitals, treating Blue Cross subscribers, receive a predetermined amount from Blue Cross. . . . " Only "member hospitals" have a direct relationship with Blue Cross; in a "nonmember hospital" admission, the Blue Cross payment is made to the subscriber, *not* to the hospital.

[2] See e.g. *Doctors Hospital* v. *Blue Cross of Greater Philadelphia*, Civil Action No. 73-1057 (E.D. Pa. August 13, 1975), *aff'd per curiam*, No. 75-2166 (3d Cir. April 28, 1976).

authorization for the creation of Blue Cross Plans in Pennsylvania was given by the enactment of the Nonprofit Hospital Plan Act, act of June 21, 1937 (P.L. 1948). These provisions are now codified at 40 Pa. C.S.A. §§ 6101-6127.

Generally speaking, the laws applicable to commercial insurers are not applicable to Blue Cross Plans. 40 Pa.C.S.A. § 6103(a). A Plan may contract only with government-operated hospitals or with hospitals approved by the Department of Public Welfare. 40 Pa.C.S.A. § 6121; 62 P.S. § 1003; 67 Pa.C.S.A. § 6102; 71 P.S. § 755-2. Blue Cross-hospital and Blue Cross-subscriber contracts are subject to Insurance Department approval. 40 Pa.C.S.A. § 6124(a).

Originally, the Blue Cross-hospital contracts called for Blue Cross to pay a flat per diem reimbursement to a hospital in order to purchase hospital service required by a subscriber-patient.

As successive Pennsylvania Insurance Commissioners began to appreciate the significance and magnitude of hospital cost inflation, a governmental policy was adopted to utilize the Blue Cross-hospital contract as a vehicle to control the rate of escalation of hospital costs. This technique was feasible because over one-half of the population of the Commonwealth of Pennsylvania is covered by Blue Cross benefits.

Accordingly, the Blue Cross-hospital contracts were revised in several stages until by 1971 the hospital no longer received from Blue Cross a flat per diem reimbursement (which had always been less than the hospital's posted "charges" (or retail price)), but rather received only the actual cost (including depreciation, etc.) of providing the service to Blue Cross subscribers. These Blue Cross-hospital contracts are complex but in general provide definitions of reimbursable costs and procedures for the resolution of disputed questions (including, where necessary, ultimate court review).

It is important to note that the cost-based Blue Cross-hospital contract is open ended in that it has a built-in price escalator; that is, being cost-based, as a hospital's allowed costs increase due to inflation, the dollar amount of the hospital's per diem reimbursement from Blue Cross also increases without the need for any further revision in the basic contract.

Effect of the Unanticipated Abandonment of Member Hospital Status by the DVHC. The Delaware Valley Hospital Council (the "DVHC"), appellant in No. 75-1691, represents a group of approximately 30 hospitals which have since August 15, 1974 refused to extend voluntarily their Blue Cross-hospital contracts (contracts which have existed, in one form or another, since the inception of the Plan in southeastern Pennsylvania in the late 1930's). It was anticipated on all sides that any new contract, like all prior contracts, would take effect retroactively to the August 15, 1974 expiration of the last preceding contract. The principal impediments to a new contract are (see Exhibit B, *infra*, 51):

(a) A demand by the DVHC-represented hospitals that where the hospital does not receive full payment for services rendered to a non-Blue Cross subscriber (*e.g.,* to an indigent patient or to a physician or other person who traditionally is not charged for hospital services), Blue Cross subscribers as a class must shoulder a specified part of these costs.[3]

(b) A demand by the DVHC-represented hospitals that the existing controls over unjustified expansion of bed capacity and duplication of expensive "big ticket" medical facilities (such as open-heart surgery units, intensive care units, burn treatment units, electronic brain and whole body scanners, cancer radiation therapy, renal dialysis, etc.) be abandoned.

The effect of the August 15, 1974 termination of the Blue Cross-hospital contracts was gradually to convert the DVHC hospitals from "member" to nonmember hospitals over the period of a year. Under the so-called "run-out" provision of the contracts, the DVHC-represented hospitals were to lose their status as "member" hospitals with respect to any particular Blue Cross subscriber on the next annual renewal date of his or her Blue Cross-subscriber contract. Thus a progressively declining proportion of all Blue

[3] Indeed, appellants in No. 75-1698 candidly concede that their aim is to eviscerate the cost control efforts of Medicare, Medicaid and Blue Cross, which refuse to pay for misutilized services, thereby encouraging more efficient hospital administration. Thus these appellants seek to have Blue Cross absorb the cost of, *inter alia,* "misutilized patient days" (J.S., p. 16), thus destroying one of the principal incentives for more efficient operation.

Cross subscribers were entitled to "member" benefits in DVHC-represented hospitals, with the last group scheduled to lose such benefits on August 15, 1975 (one year after the commencement of the run-out period). The effect of this change is illustrated by the following hypothetical example:

(a) Before the run-out, a Blue Cross subscriber who experienced a 9-day spell of hospitalization in a "member" hospital with a $150 per day rate and a $120 per day "cost"[4] might have been presented on discharge with a $90 bill computed as follows:

Hospital "charges"	$150 per day
Cost of service as determined under the Blue Cross-hospital cost reimbursement formula	$120 per day
Paid by subscriber to hospital (required coinsurance under Blue Cross-subscriber contract) (9 × $10)	$90
Paid by Blue Cross to hospital	(9 × $120) − $90 = $990
Total received by hospital	$1,080

(b) After the run-out, the impact on the Blue Cross subscriber could be dramatically different, since the nonmember status of the hospital converts the Blue Cross program to a cash indemnity plan, and the hy-

[4] Appellants in No. 75-1691 suggest that the hospitals' list prices or "charges" may be as much as 40% more than their "reasonable costs" (J.S., p. 8 n. 6), but a 25% profit or markup is utilized here for illustrative purposes.

pothetical patient would be presented on discharge with a $1,350 bill:

Hospital "charges"	$150 per day
Paid by subscriber to hospital (9 × $150)	$1,350
Indemnity paid subsequently by Blue Cross to subscriber (1 × $50 + 8 × $25)	$250
Net amount ultimately paid by subscriber ..	$1,100

Response of the Commonwealth of Pennsylvania. On August 2, 1975, prior to the final run-out of the existing Blue Cross-hospital contract with the DVHC-represented hospitals, the Pennsylvania General Assembly enacted Act No. 94. The Act has the following effects:

(a) Where a Blue Cross-hospital contract was in existence on August 2, 1975, or where it is entered into then or thereafter, the contract (including primarily the cost reimbursement feature) may not thereafter be terminated without going through a "cooling-off" procedure involving notice to the Insurance Department, investigative hearing, recommendations by the Department, and further negotiations. (This is the only concern of the appellants in No. 75-1698, since they were in no way directly involved in the dispute between Blue Cross and the DVHC-represented hospitals, but had existing contracts which became subject to the cooling-off provisions of the statute. See Jurisdictional Statement in No. 75-1698, pp. 8-9.)

(b) The remaining impact of the statute was confined to hospitals which had benefited substantially continuously from Blue Cross-hospital contracts during the *ten year* base period June 30, 1964 to June 30, 1974, but which were not covered (except for the application of the run-out period) by a Blue Cross-hospital contract on August 2, 1975 (all of the DVHC-represented hospitals fall into this classification). As to these hospitals the last approved Blue Cross-hospital contract on file with the Insurance Department was made applicable to August 2, 1975 and subsequent hospital admissions until a termination of the prior contract under the cooling-off provisions described in (a) above is effected, or unless and until the prior contract is retroactively superseded by a new agreement, voluntarily entered into between Blue Cross and the hospitals and approved by the Insurance Department. Before the district court the Commonwealth and Blue Cross argued that, properly understood, this aspect of Act No. 94 was clearly prospective in effect.

(c) In the case of hospitals covered by (b) above, the last approved Blue Cross-hospital contract was also made applicable to the operations of the hospitals during the "locked-in" period between August 15, 1974 and August 2, 1975, unless and until retroactively superseded by a new voluntary agreement as described in (b), above.

Returning to the earlier hypothetical example, if Act No. 94 had been drafted simply as a price control statute, the Blue Cross subscriber who expected

to pay $90 on discharge would still have found it necessary to pay a net of $830 for his or her spell of hospitalization:

Hospital "charges" before controls..	$150 per day
Hospital "charges" as determined under Blue Cross-hospital cost reimbursement formula adopted by Act No. 94.....	$120 per day
Paid by subscriber to hospital (9 × $120) =	$1,080
Indemnity paid subsequently by Blue Cross to subscriber (1 × $50 + 8 × $25)	$ 250
Net amount ultimately paid by subscriber	$ 830

By characterizing the Blue Cross-hospital contract as "reinstated," Act No. 94 gave the DVHC-represented hospitals "member hospital" status under the separate Blue Cross-*subscriber* contracts, thus, in the hypothetical example, restoring the Blue Cross-paid portion of the hospital bill to $990 from $250 and reducing the subscriber-paid portion from $830 to $90.

In the district court the Commonwealth and Blue Cross argued (1) that the hospitals involved were not constitutionally affected by this contract reinstatement characterization, since it in substance affected only the separate relationships between Blue Cross and its subscribers, and (2) that thus stripped of its "contract clause" overtones, the issue before the district court was simply whether the Commonwealth of Pennsylvania could constitutionally impose cost-based price controls on the hospitals for the future and with respect to the August 15, 1974-August 2, 1975 locked-in period.

ARGUMENT

A. BACKGROUND

The Magnitude of the Crisis Facing the Legislature was Great. On a National level, health expenditures over the period 1950 to 1975 have almost doubled as a percentage of Gross National Product (4.6% to 8.3%) and of personal income (5.7% to 9.9%), with further increases predicted for the future (the Department of Health, Education and Welfare estimates that by 1990, 10% to 12% of Gross National Product will be spent for health care). Hospital expenditures are even higher than overall health expenditures, so that the cost of an average hospital stay is up from $311 in 1965 to $1017 in 1975; over the same period, the average length of hospital stays declined.[5]

The situation in the area of appellant hospitals is even more egregious. Per diem hospital costs in the Philadelphia area rose from only $29.27 in 1964 to $117.83 in 1974, or 400% in 10 years, with $201.25 per diem projected for 1977 (Ex. 31).[6]

To protect themselves from exposure to this economic risk, and to assure themselves the ability to obtain adequate health care, over half the population

[5] Executive Office of the President, Council on Wage and Price Stability, Staff Report on "The Problem of Rising Health Care Costs" at 4, 9, 23, 27 (April 1976) (GPO Stock No. 052-003-00164-1).

[6] References to "Ex." herein are to correspondingly-numbered exhibits to the affidavits of Mr. Bruce Taylor, as contained in the record.

of the Commonwealth of Pennsylvania is covered by Blue Cross Plans (Taylor Affidavit, ¶ 6). Appellant Blue Cross of Greater Philadelphia alone has approximately 2,400,000 subscribers (Taylor Affidavit, ¶ 5). Thus, literally millions of residents were subjected to a severe crisis situation by the unanticipated hiatus in their hospitalization coverage.

Act No. 94 Establishes Hospitalization Rates on the Basis of an Open-Ended Formula, Not a Fixed Price. Under Act No. 94, the appellant hospitals are reimbursed on the basis of a formula which automatically increases the dollar payment to the hospitals as their eligible costs increase due to inflation. It is true, as stated by the appellants in No. 75-1691 (J.S., p. 6 n. 5), that at one time there were dollar limits in effect. But by the time Act No. 94 was enacted all such limits had been removed. See, e.g., Ex. 17, 18 and 20 as modified by Ex. 23, ¶ 4: "full reasonable costs" to be paid. Thus the statute does *not* freeze reimbursement at a fixed dollar price.[7]

The courts have recognized that the Blue Cross Plan cost reimbursement approach is an entirely appropriate and valid method of containing otherwise

[7] The dispute here is analogous to a claim that the regulated industry has a constitutional right to a "fair value" as opposed to an "original cost" rate base. Cf. *F.P.C.* v. *Hope Natural Gas Co.* 320 U.S. 591 (1944). It is the *formula* which is attacked, not a specific per diem rate for a specific hospital applicable during a specific period of time. Thus the request of the appellants for further hearing below or before a state agency (e.g. J.S. in No. 75-1691, pp. 2, 18-19, 23), is wholly inapposite, since the validity of the formula as an exercise of state legislative policy is a question of law.

unrestrained hospital cost increases, and have sustained it against challenges brought by hospitals,[8] commercial insurance carriers,[9] and non-Blue Cross subscribers.[10]

Thus, the only question is whether the formula must necessarily take into account such items as free care provided to indigents and courtesy care provided to hospital staff and their families, either by specific coverage of such items or by inclusion of an undifferentiated "plus factor" covering all such items.

The nature of the Act No. 94 formula is key to the case at bar. To be sure, a fixed price formula might tend toward the confiscatory over time, as inflation caused the underlying costs to the hospitals to increase. But that is not the case here. As noted immediately above, the formula incorporated by the statute is open ended and has a built-in price escalator, so that it adjusts automatically for inflation.

Unfortunately, the dissenting judge below seems to have misunderstood this point:

> "The effect of the Act is to force contracting hospitals to continue to provide care to subscriber

[8] *Frankford Hospital* v. *Blue Cross of Greater Philadelphia,* Civil Action No. 74-2281 (E.D. Pa.) (June 8, 1976) (a copy of the unreported decision is annexed as Exhibit A).

[9] *Travelers Ins. Co.* v. *Blue Cross of Western Pa.,* 361 F.Supp. 774 (W.D.Pa. 1972), *aff'd,* 481 F.2d 80 (3rd Cir. 1973), *cert. denied,* 414 U.S. 1093 (1974); *New Jersey Association of Independent Insurance Agents* v. *Hospital Service Plan of New Jersey,* 343 A.2d 739, 68 N.J. 213 (1975).

[10] *Borland* v. *Bayonne Hospital,* 300 A.2d 584, 122 N.J. Super. 387 (Ch. Div. 1973), *aff'd,* 344 A.2d 331, 136 N.J. Super. 60 (1975).

> patients at increasing current costs, while reimbursement from the hospital plan corporations is based on previously negotiated cost calculations and formulae . . . [S]ubscriber patients will be paying for hospital services, through the hospital plan corporation, rates which do not fully reflect the escalating costs caused by the inflationary spiral." Jurisdictional Statement in No. 75-1691, pp. A27-A28.

It may well be that had he perceived correctly the nature and effect of the open-ended cost-of-service formula, the dissenting judge himself might have joined in the majority's assessment of its validity.

The Formula Incorporated by the Statute is the Medicare Formula Which Was Developed by the American Hospital Association. The reimbursement formula codified by Act No. 94 is based on the same cost accounting principles as utilized by the Federal government in computing Medicare payments. These procedures require that all legitimate costs associated with the treatment of Blue Cross subscribers be paid by the Plan. These costs include not only payroll, medicine, supplies and meals, but also encompass maintenance expenses, depreciation, and interest on borrowed funds. The formula adopted by Act No. 94 incorporates by reference the appropriate Medicare rules, regulations and interpretations, which provide in detail procedures to be utilized by independent certified public accountants in fixing final payments.

The Medicare program is based on the principle that the costs attributable to a given patient should

be borne by that patient or the third-party payor responsible for reimbursing the hospital for services rendered that patient. In developing the extensive procedures necessary to accomplish this result, Congress, and the Secretary of Health, Education and Welfare, borrowed substantially from the "Principles of Payment for Hospital Care" approved by the American Hospital Association in September, 1953 (Ex. 35). Although appellants assert that the Plan should bear the costs attributable to providing care to indigents, uncollectible amounts other than those of Blue Cross subscribers, providing charity allowances and underwriting certain educational and research activities, the 1953 AHA Principles state such is improper.

Thus, appellants would erect as their constitutional prerogative a right to include within the formula payments which even their own Association conceded was improper at the time Medicare was first enacted.

The Formula Incorporated by the Statute is Applicable Only to Hospitals Who Have Benefited Greatly from it in the Past. Except for the "cooling off" procedure objected to by the appellants in No. 75-1698, the impact of Act No. 94 by its terms applies only to hospitals which have benefited from the Blue Cross reimbursement arrangements substantially continuously for at least 10 years. To understand this point fully, one must appreciate that there exist two approaches to reimbursement of hospitals:

(a) First, there is the Blue Cross system. Under this approach, hospitals receive payment for allowable "costs", such payment being guaranteed by Blue Cross. The ability of Blue Cross to honor such guarantee is policed by the Commonwealth, which regulates reserves, rates to subscribers, etc.

(b) Second, there is the non-Blue Cross system. Under this approach, hospitals bill their full retail "charges", and collect what they can, when they can, net of collection costs, from each individual patient.

Appellants thus may forego above-cost collections in exchange for the certainty of payment, or they may charge what the traffic will bear and take the risk that the charges are uncollectible. But there is nothing in the decisions of this Court that suggests, much less requires, that a State must give the appellant hospitals the best of both worlds.[11]

The Formula is a Matter of Policy, Not Constitutionality. It should be re-emphasized that the case at bar does not deal with the question whether a cost-based reimbursement formula *may* include certain disputed items. Rather, it deals with whether the rate formula *must* include those items. The district court found that the rate formula adopted by Pennsylvania was permissible. Similarly, the Massachusetts formula

[11] The hospitals on behalf of which the DVHC negotiates have split into two groups. The hospitals represented by the DVHC in this litigation represent in the aggregate approximately one-half of the nonprofit charitable beds served by Blue Cross of Greater Philadelphia. The remaining beds are represented by the seven local medical school hospitals and certain other hospitals which, although represented by DVHC in negotiations, voluntarily settled their dispute with Blue Cross (Ex. 24, 25 and 26).

has been sustained by this Court against allegations that it failed to provide fair reimbursement for seven specific items.[12]

Moreover, it should be noted that all but one of appellant hospitals accepts Hill-Burton funds from the Federal government (Taylor Affidavit, ¶ 84), thereby obligating themselves to provide certain free care to indigents.[13] It is difficult to understand why appellants believe they have a constitutional right to collect from Blue Cross subscribers the cost of rendering the indigent care which they are required by law to provide.[14]

Other disputed omissions from the Pennsylvania formula are similar. For example, to read into the Constitution a requirement that hospitals be reimbursed for free care provided to highly compensated doctors and their families is, to say the least, novel.

To be sure, reasonable men may differ as to whether the disputed items should be reimbursed.[15] It is clear,

[12] *Murphy Nursing Home* v. *Rate Setting Commission*, 305 N.E. 2d 837 (Mass. 1973), *appeal dismissed*, 417 U.S. 962 (1974).

[13] 42 U.S.C. § 291 *et seq.* See *Corum* v. *Beth Israel Medical Center*, 359 F.Supp. 909, 917 (S.D.N.Y. 1973).

[14] Appellants in No. 75-1691 take the district court to task (J.S., pp. 19-20) for allegedly failing to perceive the charitable nature of the appellants, all of which are nonprofit charitable institutions. But it is precisely because appellants are committed to charity that they cannot, certainly as a constitutional matter, force the Blue Cross subscriber to pay for the costs of the work which the hospitals hold out as a charity. Appellants' view of "charity" smacks of a private tax levied upon those fortunate enough to enjoy Blue Cross benefits.

[15] *Compare* the positions of Insurance Commissioners Maxwell and Denenberg with the position of Commissioner Sheppard, Exhibit A at 32 n.5, 33 n.6 and 36 n.9.

however, that the question is not of constitutional proportions.

Appellants Had No Actual Expectation of Receiving their List Prices for the Locked-In Hospitalization Services. Appellant hospitals did not in fact rely on being able to charge non-subscriber rates to Blue Cross subscribers during the August 15, 1974-August 2, 1975 "locked-in" period. Although appellants in their Jurisdictional Statements claim that their reasonable expectations have been upset, this is not a case where the hospitals' conduct would have been different in fact if enactment of Act No. 94 had been foreseen from the beginning.

Under past practice, contractual agreements between appellant hospitals and appellee Blue Cross have always been made retroactive (Taylor Affidavit, ¶ ¶ 27, 32, 34, 42). Indeed, both appellees and appellant hospitals have all along taken the position that whatever agreement is reached in the current contract negotiations will be made retroactive to the August 15, 1974 expiration of the last contract between the parties.[16] To return to the earlier hypothetical example,

[16] See letter from counsel for DVHC (Ex. 29), annexed as Exhibit B hereto. Thus the argument of appellants in No. 75-1691 that the typical Blue Cross subscriber who renewed his coverage after July 31, 1974 in effect did so without justifiable expectation of coverage in a DVHC—represented hospital (J.S., p. 15 n. 12) is obviously specious. The 2,400,000 members of the general public were entitled to assume, particularly in view of the enormous consequences of a shift to nonmember status, that the dispute would ultimately be settled retroactively—as it had always been before.

the hospitals were negotiating for a change in the cost formula which might increase the $120 per diem cost to perhaps $125, but they had no expectation that they would receive precisely their retail charge ($150) or anything close to it. Thus, on August 1, 1974, immediately prior to the signing of Act No. 94, no hospital administrator knew what he was going to be paid for Blue Cross subscriber admissions for the prior 11½ months.

Accordingly, appellants can not complain that the Pennsylvania legislature has impaired their "vested" rights to a specified payment level or their legitimate expectations to such effect, since appellants themselves held open the final rate of payment for Blue Cross subscriber admissions during the hiatus period which the statute seeks to correct.

The Issues Involved Herein are Virtually Mooted by the Timing of the Instant Litigation. The ability of a State to provide a "cooling off" procedure for future Blue Cross-hospital disputes, and its ability to regulate hospital charges prospectively from the date of enactment of a statutory rate regulation scheme are soundly based in the decisions of this Court. Thus, the only non-frivolous issues involved below dealt with the regulation of hospital charges applicable to Blue Cross subscribers for the August 15, 1974-August 2, 1975 locked-in period.

Under the terms of the payment documentation for reimbursement of the DVHC-represented hospitals during this period, virtually all of appellants' money

claims for the locked-in period have now been settled by accord and satisfaction between the parties, thus mooting this issue.[17]

B. LEGAL ANALYSIS

The Pennsylvania legislature acted reasonably and therefore constitutionally in utilizing the restoration of the Blue Cross-hospital contract as the technique for temporarily resolving the hiatus in hospitalization regulation caused by the unexpected refusal of the DVHC-represented hospitals to enter into new Blue Cross-hospital contracts subject to Pennsylvania Insurance Department regulatory review. Appellants' arguments to the contrary do not raise substantial constitutional issues.

The Power of the General Assembly to Adopt the Statutory Reimbursement Formula is Clear. It is obvious that the rates that may be collected by providers of health care services are sufficiently affected with a public interest to be amenable to regulation under the police power of the State. *Nebbia* v. *New York,* 291 U.S. 502 (1934) (rates for milk sales); *Munn* v. *Illinois,* 94 U.S. 113 (1877) (rates for grain elevators).

Indeed, legislatures have particularly broad discretion in framing solutions in the area of public health care. Thus, in the three cases in this area of which we are aware brought before this Court on

[17] A copy of the payment documentation (Ex. C to Amended Complaint) is annexed as Exhibit C hereto, *infra* page 54.

direct review in the past five years, decisions upholding the legislative judgment have been summarily affirmed:

> (1) *Clemons* v. *United States,* No. 75-348 (Salary equivalency provisions of amendment to Social Security Act establishing maximum amounts to be paid to providers of physical therapy services furnished under arrangements with provider and implementing regulations do not deprive physical therapists of equal treatment under law; legislation is good faith attempt to limit costs to reasonable fees for physical therapy services). 46 L. Ed. 2d 381 (1975).
>
> (2) *Rastetter* v. *Weinberger,* No. 74-402 (Congress may validily exclude chiropractors and naturopaths from Part B of Medicare coverage). 419 U.S. 1098 (1975).
>
> (3) *Association of American Physicians and Surgeons* v. *Mathews,* No. 75-361 (Professional Standards Review Law with respect to Medicare and Medicaid is constitutional). 46 L. Ed. 2d 299 (1975).

The only other case in this area of which we are aware brought before this Court on direct appeal had the appeal dismissed for want of a substantial Federal question. That case bears striking similarities to the case at bar:

> (4) *Murphy Nursing Home, Inc.* v. *Rate Setting Commission,* 305 N.E.2d 837 (Mass. 1973)

(Massachusetts formulae, ceilings and limitations on rates of reimbursement to nursing homes are valid, as is rate freeze on reimbursement to skilled nursing homes but not hospitals or unskilled nursing homes), *appeal dismissed,* 417 U.S. 962 (1974).

Similarly, certiorari has been denied in all recent cases in this area of which we are aware brought before this Court within its discretionary jurisdiction:

(5) *Travelers Ins. Co.* v. *Blue Cross of Western Pa.,* 481 F.2d 80 (3rd Cir. 1973) (Pennsylvania's regulation of Blue Cross-hospital contracts is not unconstitutional as to commercial insurers), *cert. denied,* 414 U.S. 1093 (1974).

(6) *New Jersey Chapter Incorporated of the American Physical Therapy Association, Inc.* v. *Prudential Life Ins. Co.,* 502 F.2d 500 (D.C. Cir. 1974) (salary-equivalency standards issued by Medicare fiscal intermediary for determining reasonable cost of services performed by independent physical therapists were proper), *cert. denied,* 420 U.S. 1004 (1975).

Finally, every decision of which we are aware not brought before this Court has sustained the constitutionality of the Blue Cross system:

(7) *New Jersey Association of Independent Insurance Agents* v. *Hopsital Service Plan of New Jersey,* 343 A.2d 739, 68 N.J. 213 (1975) (New Jersey Blue Cross arrangements are not unconstitutional as to commercial insurers).

(8) *Borland* v. *Bayone Hospital,* 300 A.2d 584, 122 N.J. Super. 387 (Ch. Div. 1973), *aff'd,* 344 A.2d 331, 136 N.J. Super. 60 (1975) (New Jersey Blue Cross arrangements are not unconstitutional as to non-Blue Cross subscribers).

The Power of the General Assembly to Make the Reimbursement Rate Partly Provisional is Clear. In establishing the reimbursement formula under Act No. 94, the General Assembly had three choices: the rate could be made provisional in whole (*i.e.,* subject to subsequent readjustment in any event), provisional in part (*e.g.,* subject to readjustment in the event of subsequent voluntary agreement on rates between the parties), or final (*i.e.,* not subject to any subsequent readjustment).

When it imposed a rate freeze on Medicaid payments to skilled nursing homes, Massachusetts opted for fully provisional rates (see *Murphy Nursing Home,* supra). Pennsylvania, on the other hand, imposed partly provisional rates by Act No. 94. Although appellants might have been better off with fully provisional rates than with partly provisional rates, there is no constitutional requirement that rates be provisional to any extent whatsoever.

In sustaining the constitutionality of the Taft-Hartley Act of 1947, this Court recognized the validity of legislation requiring that contractual arrangements be "continued for a time while further efforts [are]

made to settle the dispute." *Steelworkers* v. *United States,* 361 U.S. 39, 41 (1959).[18]

Similarly, prior to enactment of the Railway Labor Act, in sustaining the constitutionality of the Adamson Law of 1916, this Court held that the legislative power "extend[s] to doing that which was essential to prevent operation [of the railroads] from being completely stopped by filling the interregnum created by an absence of a conventional standard of wages because of a dispute on that subject between the employers and employees by a legislative standard binding on employers and employees for such a time as might be deemed by the legislature reasonably adequate to enable normal conditions to come about as the result of agreements as to wages between the parties." *Wilson* v. *New,* 243 U.S. 332, 351 (1917).

[18] Indeed, a recent amendment to the Taft-Hartley Act provides that if a labor dispute affecting a health care institution (defined to include nonprofit hospitals such as appellants) would substantially interrupt the delivery of health care in the locality concerned, a board of inquiry may be established and "[there]after . . . and for 15 days after any such board has issued its report, no change in the status quo in effect prior to the expiration of the contract in the case of negotiations for a contract renewal, or in effect prior to the time of the impasse in the case of an initial bargaining negotiation, except by agreement, shall be made by the parties to the controversy." 29 U.S.C. § 183 (c), as added by Public Law 93-360, 88 Stat. 396. The maximum cooling off period under 29 U.S.C. § 183 is 30 days; under 29 U.S.C. §§ 178-180 the maximum period is 80 days. In view of the presumably greater resources of hospitals as compared with individual wage earners, and the virtually permanent relationship between Blue Cross and its member hospitals, the approximately one year cooling off period selected by the Pennsylvania General Assembly was obviously within the ambit of legislative discretion.

Thus, final rates could lawfully have been imposed on the hospitals, and the fact that the General Assembly was *more* solicitous of the hospitals can not defeat the validity of Act No. 94.

The Power of the General Assembly to Apply the Formula to the Hiatus Period is Clear. There is no constitutional impediment to applying the Act No. 94 formula to the 11½ month August 15, 1974-August 1, 1975 locked-in period.

"The Fourteenth Amendment does not make an act of state legislation void merely because it has some retrospective operation." *Chase Securities Corp.* v. *Donaldson,* 325 U.S. 304, 315 (1945). Rather, the constitutionality of a retrospective statute depends upon a balancing of three major factors: the nature and strength of the public interest served by the statute, the extent to which the statute modifies or abrogates preenactment rights, and the nature of the rights which the statute alters. C. Hochman, "The Supreme Court and the Constitutionality of Retroactive Legislation," 73 Harv. L. Rev. 692 (1960).

In the instant case, the public interest was great, the modification of rights was modest[19], and the "rights"

[19] As noted above, the statute is limited in time (i.e., to 11½ months), coverage (*i.e.,* to hospitals having benefited substantially continuously for at least 10 years from the system of guaranteed payments policed by the Commonwealth), extent (*i.e.,* most costs are reimbursed, with only free care and other disputed items omitted in reliance on the American Hospital Association-based Medicare formula), effect (any settlement reached by the parties is made effective as of August 15, 1974), and scope (most disputed claims having been settled by accord and satisfaction).

that appellants claim were altered were mere hopes or negotiating positions and not legitimate expectations.[20]

Moreover, Act No. 94 is also clearly justified as a measure to fill an unexpected gap in a rate regulatory system. *Fleming* v. *Rhodes,* 331 U.S. 100 (1947) (legislation may be made effective as of a date prior to enactment in order to fill a gap in a regulatory system); Hochman, *supra,* at 719.

Indeed, this Court has made clear that even when the Contract Clause is implicated, there is room for a legislative balancing of public and private interests which will not be disturbed by the courts. *El Paso* v. *Simmons,* 379 U.S. 497 (1965) (Texas land law).

All of Appellant's Arguments are Legal in Nature. Appellants now assert that, even if their motion below for summary judgment was properly denied, nevertheless it was improper to have granted appellees' motion below for summary judgment. At a minimum, they now allege, the lower court should have required a trial of disputed issues of fact.

Appellants cite case authority for the proposition that cross-motions for summary judgment do not *require* the court to grant one or the other. This is true, but irrelevant. There is no occasion for remand of the instant case. No facts are in dispute. The only dispute revolves around the legal effect (*i.e.,* the constitution-

[20] As noted above, the terms of final settlement for admissions to appellant hospitals for the 11½ month hiatus period have been held open by appellants themselves, so that they can not reasonably claim to be "vested" beyond the regulatory power of the Commonwealth of Pennsylvania.

ality) of a partly provisional rate formula that does not include reimbursement to hospitals for free care and other desired elements,[21] and of the application of such formula to the locked-in period.

The dissenting judge below brought this remand issue to the attention of the district court, as appellants note in their Jurisdictional Statements. A factual inquiry into confiscatory effect conceivably could be appropriate if (as the dissenting judge thought) Act No. 94 set a fixed price unresponsive to inflationary pressures. However, quite to the contrary, the statute is open-ended and automatically adjusts for inflation. And this fact is not disputed by appellants.[22]

Thus, as Circuit Judge Van Dusen and District Judge Weiner recognized in their opinion below, "Since the facts are not in dispute, there remain solely questions of law," and their grant of summary judgment for appellees was clearly correct.

[21] See note 7, *supra* at p. 12.

[22] The terms of the applicable Blue Cross-hospital contract as last amended provide for "full allowable costs with no ceiling upon a final accounting." Jurisdictional Statement in No. 75-1698, p. 8.

CONCLUSION

For the reasons set forth above, "it is manifest that the questions on which the decision of the cause depends are so unsubstantial as not to need further argument" [Supreme Court Rule 16(1)(c)], and the decision of the district court should be summarily affirmed.

Respectfully submitted,

WILLIAM E. ZEITER
ROY K. MEILMAN
2100 The Fidelity Building
Philadelphia, Pennsylvania 19109

MICHAEL VON MOSCHZISKER
MARGARET ANDERSON
Office of the Attorney General
Eastern Regional Office
Room 206 State Office Building
Philadelphia, Pennsylvania 19130

BONNIE BRIGANCE LEADBETTER
Office of the District Attorney
2300 Centre Square West
Philadelphia, Pennsylvania 19102

Of Counsel:

MORGAN, LEWIS & BOCKIUS

June 23, 1976

Exhibit A

IN THE

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF PENNSYLVANIA

FRANKFORD HOSPITAL

v.

BLUE CROSS OF GREATER PHILADELPHIA

CIVIL ACTION

No. 74-2281

MEMORANDUM AND ORDER

NEWCOMER, J. June 8, 1976

This suit grows out of a controversy about the criteria for reimbursing hospitals for services rendered to Blue Cross subscribers. Frankford Hospital, individually, seeks damages and injunctive relief against Blue Cross of Greater Philadelphia on the ground that it has violated the federal antitrust laws.[1] On September 25, 1975, this court certified plaintiff the representative—for the purpose of injunctive relief only—of a class consisting of all Pennsylvania non-profit hospitals, clinics, and medical centers that have had a hospital contract with defendant in force at any time during the period September 4, 1970 to September 4, 1974. Extensive discovery followed. At its completion defendant filed a motion for summary judgment. For the reasons stated below this motion will be granted.

[1] Sherman Act §§ 1 and 2, 15 U.S.C. §§ 1 and 2. Plaintiff also alleges a pendent claim under Pennsylvania common law doctrines outlawing certain restraints of trade.

FACTS NOT IN DISPUTE

Defendant, Blue Cross of Greater Philadelphia, (hereinafter Blue Cross) is a nonprofit corporation which operates hospital plans whereby its subscribers are provided hospitalization and related health services. Defendant is certified to do business in the Commonwealth by the Pennsylvania Insurance Department.[2] Defendant, a member of the Blue Cross Association, headquartered in Chicago, Illinois, is the oldest of five Blue Cross plans in Pennsylvania, and has approximately 2,400,000 subscribers in the Philadelphia area.

Blue Cross is not an insurer in the classic sense of that term. In its contracts with subscribers it agrees to furnish them needed health care services in return for premiums paid by them, or on their behalf (e.g. by employers). In order to cary out these obligations Blue Cross contracts with eligible hospitals.[3] In a typical situtation, a subscriber goes to a member hospital,[4] presents his or her Blue Cross card, and receives health care services and the hospital sends the bill directly to Blue Cross. On the other hand, a

[2] At all times material to this action, Blue Cross existed and operated pursuant to the Nonprofit Hospital Plan Act, Act of June 21, 1937, P.L. 1948, § 1 *et seq.*, 40 P.S. § 1401 *et seq.*, as amended by the Act of November 15, 1972, P.L. 1063, No. 271, § 6101 *et seq.*, 40 Pa.C.S.A. § 6101 *et seq.* Certification of nonprofit hospital plans is provided for in 40 Pa.C.S.A. § 6102.

[3] As defined in 40 Pa.C.S.A. § 6121.

[4] Member hospitals are those which have contracts with Blue Cross.

patient insured under a traditional, private health insurance policy is billed for the services he receives and is entitled to receive cash indemnification by his insurer in an amount determined by his particular policy.

Some of Blue Cross' subscriber agreements include indemnification provisions together with service benefit provisions. The indemnity clause comes into play when a subscriber receives care from a nonmember hospital. Under most plans, Blue Cross' obligation is a relatively small fraction of the total charge for the service. For example, a subscriber may collect fifty dollars for the first day of hospitalization and twenty-five dollars for each subsequent day while the hospital's charge exceeds two hundred dollars per day. Blue Cross' role as an indemnity insurer of health care bills is relatively modest, compared to its service benefits business. Apparently, Blue Cross could—as a legal, if not a practical matter—refuse to underwrite any indemnity agreements.

Both the rates Blue Cross charges to subscribers and its rates of payments to hospitals must be approved in advance by the Insurance Department before they can go into effect. 40 Pa.C.S.A. § 6124. At all times material to this action, the Pennsylvania Insurance Department has aggressively regulated Blue Cross' contractual relationships with subscribers and with hospitals. Prior to 1967, there were at least six different agreements between Blue Cross and various hospitals in the Philadelphia area. The Department instructed Blue Cross to develop a uniform contract. It

particularly stressed that this contract should include the cost accounting principles upon which reimbursement under the federal Medicare Program was based. At the end of 1967, defendant submitted a proposed uniform cost contract between Blue Cross and Philadelphia area hospitals. The Insurance Commissioner, David O. Maxwell, disapproved it. In his notice of disapproval the Commissioner stated, *inter alia,* that Blue Cross should neither have to pay any portion of the hospitals' unreimbursed outpatient cost, nor to pay for depreciation or for miscellaneous unidentified costs under formulas which did not include specific incentives to hospitals to control costs.[5] Mr.

[5] "Section 1-11 of Exhibit A provides for the allowance of certain unreimbursed outpatient costs. [This results from the rendering of services to persons who are not Blue Cross subscribers and who do not fully pay their hospital bills.] The basis of payment is, generally the ratio of Blue Cross inpatient days to total inpatient days times outpatient costs for which the hospital has not been reimbursed from any source. Blue Cross would of course continue to pay for outpatient costs incurred by its subscribers."

". . . It can therefore truthfully be described as an involuntary contribution by Blue Cross subscribers to the maintenance of emergency and clinical outpatient services."

• • •

"In my opinion, the maintenance of these essential facilities is a community responsibility, including federal, state and local governments as well as eleemosynary institutions and the public. It is not fair to shift that part of the burden which the community is neglecting to bear to Blue Cross subscribers without their consent and in accordance with a method of calculation largely unrelated to the cost to the hospital of proving outpatient services." Letter to Mr. Thomas F. Manley, President, Blue Cross of Greater Philadelphia, from Insurance Commissioner, David Maxwell (undated), Exhibit E to Affidavit of Bruce Taylor, President, Blue Cross of Greater Philadelphia, pp. 8-9.

Maxwell's successors—Commissioners George F. Reed, Herbert S. Denenberg, and William J. Sheppard—adhered to the position that any contract between Blue Cross and Philadelphia area hospitals must include quality controls and ceilings on total cost reimbursement.[6]

After Commissioner Maxwell's rejection of the 1967 proposed Uniform Cost Contract, Blue Cross resumed negotiations with the hospitals and a new agreement[7] was reached by them and subsequently approved by the Commissioner. In 1971, Blue Cross resubmitted to the Pennsylvania Insurance Department for its approval a request for increases in rates charged to subscribers. Commissioner Denenberg's denial of the request sparked new, intensive negotiations between Blue Cross and the hospitals (which were represented

[6] In a letter to Blue Cross dated November 6, 1973, Insurance Commissioner Denenberg made the following comments about "free care":

"This department cannot and will not approve the submitted cost-plus factor. I draw your attention to several basic reasons. First, free care, the alleged cause of the plus factor, is not a cost connected with Blue Cross coverage . . . Blue Cross cannot pay for services outside of Blue Cross coverage.

In short, Blue Cross, itself a nonprofit corporation is not authorized to make contributions or gifts to hospitals in recognition of free services which may have been provided to the community. . . ."

• • •

"Sixth, the provisions and financing of free care service is a community problem. Costs of free care should be shared by the entire community through appropriations from government funds or otherwise." Exhibit M to Affidavit of Bruce Taylor, pp. 1-3.

[7] Uniform Cost Contract—1967.

in the negotiations by the Delaware Valley Hospital Counsel, hereinafter DVHC). The Commissioner attended many of the negotiating sessions. These efforts resulted in the Hospital Agreement of 1971, the terms of which reflected Commissioner Denenberg's negotiating guidelines.

Negotiations to reach agreement on a contract to succeed the 1971 Agreement commenced in March 1973. The negotiations, however, were not very successful, and before they were completed the 1971 Agreement expired. At this juncture the hospital split ranks. In September, 1974, a number of the DVHC-represented hospitals became non-member hospitals. A number of other DVHC-represented hospitals, including the Philadelphia medical school hospitals, agreed with Blue Cross to extend the terms of the 1971 Agreement during the pendency of negotiations. In November, 1974, a number of Philadelphia hospitals reached agreement with Blue Cross on a contract. The Insurance Department approved it. This "1974 Agreement," which was retroactive to July 1, 1974, has been adhered to by all Philadelphia medical school hospitals (including one which did not actually sign it) and has been signed by some DVHC-represented hospitals and a number of community hospitals. Approximately 40 DVHC-represented hospitals refused to sign it.

The situation in which a large number of Philadelphia area health care facilities were not Blue Cross member hospitals created extreme problems for some

subscribers in need of treatment. Both Blue Cross and the DVHC took out advertisements in newspapers at various times to inform the public about which hospitals were and were not under contract with Blue Cross to provide subscriber services. Some Blue Cross subscribers sought services in non-member hospitals either by mistake or because of the exigencies of medical emergencies, or for other reasons. It was an unhappy surprise to many when they learned that they were personally liable for substantial bills. On August 2, 1975, the Commonwealth of Pennsylvania enacted Act No. 94 of 1975, (40 P.S. § 6124c). It reinstated, retroactively, the 1971 Hospital Agreement between Blue Cross and the non-member DVHC hospitals.[8] Under Act 94, the Blue Cross-hospital contracts may be terminated only after notice is first given to the Insurance Department which then can initiate various procedures during a "cooling off" period. Thirty-one hospitals sent notice to the Commissioner on and after August 25, 1975. In a decision rendered on May 21, 1976, Commissioner Sheppard ruled that he would not approve termination of the contractual relationship. At the same time, he set forth findings—which are comparable to guidelines—on the two remaining dis-

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[8] The constitutionality of this act was upheld by a three-judge court in Guest *v.* Fitzpatrick, Civil Action No. 75-2306 (E.D. Pa. Feb. 27, 1976), *appeal pending*. Judge Luongo dissented from the majority opinion of Judge Weiner and Circuit Judge Van Dusen.

puted areas in the negotiations. Clearly, state regulation of Blue Cross hospital contracts is still vigorous.[9]

Frankford Hospital contends that the 1967 and 1971 Agreements were unreasonable because under them Blue Cross paid for less than its proper share of the operating cost attributable to the treatment of Blue Cross subscribers. It claims that Blue Cross used its position of power and dominance to coerce the hospitals into signing the agreements. The "discount" on hospital services Blue Cross achieved under the contracts, as compared to what non-subscribers and their private insurers had to pay, was allegedly exploited to Blue Cross' advantage in further consolidating a monopoly in the health insurance market. Frankford Hospital asks the court to find that the 1971 Agreement is illegal, and to order defendant Blue Cross to offer to enter into a superceding agreement with members of the plaintiff class. Under the court-ordered contract Blue Cross would pay a pro-

[9] Commissioner Sheppard ordered that the termination of the contracts be suspended for ninety days. He observed that

> "the parties should be able to conclude [the negotiations] successfully within the very near future. . . ." Defendant Exhibit V, p. 3.

It would appear that Commissioner Sheppard, unlike some of his predecessors, is willing to approve a hospital contract under which Blue Cross bears some share of free care and bad debt costs. He stated:

> "[I]t is appropriate and proper for Blue Cross, on behalf of its subscribers, to bear an appropriate portion of certain free care and bad debt costs of member hospitals, after crediting against such free care and bad debt costs the resources available to hospitals for such purposes from sources other than patient payments." p. 2.

rated share of all operating costs, which included bad debts, free care, and "working capital requirements." Thus, although the plaintiff's theory of liability relates to events occurring in the four years prior to September 4, 1974, its prayer for relief rests on the assumption that federal antitrust law preempts the Commonwealth's Act 94, and this court is therefore obligated to declare unreasonable and unlawful the very contract which the legislature recently reinstated. Blue Cross' principal defense is that the McCarran-Ferguson Act expressly exempts from the federal antitrust laws the activities of which the plaintiff complains. It argues that federal law has, by its own terms, reserved these areas in the first instance for state regulation. Because our decision is firmly grounded on the McCarran-Ferguson Act, we do not discuss Blue Cross' defense based on *Parker* v. *Brown*, 317 U.S. 341 (1943).

McCARRAN-FERGUSON ACTS

Frankford Hospital has charged Blue Cross with restraining trade, in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1,[10] and with monopolizing and attempting to monopolize, in violation of Section 2 of that Act.[11] Blue Cross contends that it has not

[10] "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several states . . . is declared to be illegal. . . ."

[11] "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several states . . . shall be deemed guilty of a misdemeanor. . ."

violated the precepts contained in these Sherman Act provisions and, in any case, these rules themselves are inapplicable to the actions herein challenged by the language of the McCarran-Ferguson Act, 15 U.S.C. §1011 *et seq.* Section 1012(b) provides in pertinent part:

> ". . . The Sherman Act . . . shall be applicable to the *business of insurance* to the extent that such business is not *regulated* by State Law." (emphasis supplied)

Excluded from the protection of this exemption are certain practices, namely—boycott, coercion or intimidation. Section 1013(b) of 15 U.S.C. provides:

> "Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce or intimidate, or any act of boycott, coercion, or intimidation."

Substantially similar arguments to those advanced by plaintiff in this case were adjudicated in *Travelers Insurance Company* v. *Blue Cross of Western Pennsylvania,* 361 F. Supp. 774 (W.D. Pa. 1972), aff'd 481 F.2d 80 (3d Cir.) *cert. denied* 414 U.S. 1083 (1973). After a lengthy trial the district court dismissed plaintiff's complaint on the alternative grounds (a) that the defendant could avail itself of the McCarran-Ferguson Act exemption because its contracts with hospitals were part of the business of insurance; these contracts were aggressively regulated by the Commonwealth of Pennsylvania; and the defendant

had not, in connection with these contracts, accompished an unreasonable restraint of trade through boycott, coercion, or intimidation as those terms are defined in 15 U.S.C. § 1013(b); and (b) assuming that the McCarran-Ferguson Act exemption did not apply, Blue Cross of Western Pennsylvania did not engage in any unlawful monopolization or restraint of trade. The Third Circuit affirmed on each of these grounds.

It is unnesssary to pass beyond the McCarran-Ferguson Act issue in order to decide the present motion. *Travelers* held that the rates Blue Cross of Western Pennsylvania charged its subscribers were so interrelated with the terms of Blue Cross' hospital contracts that the latter should be considered part of the business of insurance. 481 F.2d at 83. That conclusion was based on facts which were alike in all material respects to the undisputed facts in this case. Moreover, the argument that *Travelers* should be distinguished from the instant case either because it involved a different Blue Cross plan and a different set of negotiations, or because a suit brought by a private insurance carrier presented the questions in a different light than suit brought by a class of hospitals, was destroyed by the recent affirmance of *Doctors Hospital* v. *Blue Cross of Greater Philadelphia,* Civil Action No. 73-1057 (E.D. Pa. Aug. 13, 1975), *aff'd per curiam* No. 75-2166 (3d Cir. April 28, 1976). This narrows our task to making a determination whether there is any triable issue of material fact with respect to Frankford Hospital's assertions that

Blue Cross of Greater Philadelphia has carried out acts of boycott, coercion or intimidation prohibited by 15 U.S.C. § 1013(b).[12]

All doubts as to the existence of a genuine issue as to a material fact must be resolved against the party moving for summary judgment. *Lockhart* v. *Hoenstine,* 411 F.2d 455 (3d Cir. 1969), *cert. denied* 396 U.S. 941 (1970). At the same time, general allegations which do not show facts in detail and with precision are insufficient to prevent the award of summary judgment. *Tunnell* v. *Wiley,* 514 F.2d 971, 976 (3d Cir. 1975), *Engl* v. *Aetna Life Insurance Co.,* 139 F.2d 469, 473 (2d Cir. 1973). A party who resists summary judgment cannot hold back his evidence until the time of trial, *Robin Construction Co.* v. *United States,* 345 F.2d 610, 613 (3d Cir. 1965), and this is particularly true when the party has taken extensive discovery and has been given every reasonable opportunity to build a record and to draw the court's attention to favorable selections from it.[13]

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[12] Because we conclude that § 1013(b) is inapplicable, it is unnecessary for us to decide whether Blue Cross would be entitled to summary judgment on the ground that its activities in the Philadelphia area did not constitute unlawful monopolization or restraint of trade.

[13] After oral argument on this motion the court granted the defendant's motion to strike plaintiff's affidavits on the ground that they failed to conform to the requirements of Rule 56(e). Plaintiff was given leave to submit additional affidavits and to file a supplemental brief pointing out pertinent portions of deposition testimony. Order of May 20, 1976.

We find that no material facts are in dispute. The crux of this case is not what Blue Cross has done, but how its actions should be characterized, in the context of section 1013(b). Some hospital administrators have repeatedly asserted that Blue Cross has coerced their institutions to try to force them to sign contracts. Some hospitals have succumbed to the alleged coercion; others have not. Blue Cross does not deny that a hospital which changes from member to non-member status suffers adverse financial consequences, nor that the administrators of a hospital operating under either the 1971 or 1974 Agreement might believe that Blue Cross is not assuming a fair share of hospital costs. But defendant insists that nothing it is doing is coercion. To the contrary, it says it is doing the business that the legislature has intended it to do. In fact, some of the contractual provisions objected to by the plaintiff have been more or less frozen into Blue Cross' negotiating position by the decisions of the Insurance Department.

The terms, "boycott, coercion, or intimidation," must be interpreted with attention to the structure of the statutory provisions to which they are related. The Sherman Act proscribes practices which are monopolistic or are otherwise unreasonable restraints of trade. The McCarran-Ferguson Act creates an exemption from the Sherman Act provisions, but at the same time allows for an exception to the exemption. In this context, the terms, boycott, coercion, and intimidation, cannot be given as broad a meaning as they might have if used to define unreasonable re-

straint of trade. Otherwise, the Section 1013(b) exception would all but swallow up the body of the McCarran-Ferguson exemption. The exception must have been aimed at particular known practices in the insurance industry which Congress intended to outlaw irregardless of any efforts undertaken by the state to eliminate them through regulation. In *Meicler* v. *Aetna Casualty and Surety Co.*, 372 F. Supp. 509 (S.D. Texas 1974) *aff'd* 506 F.2d 732 (5th Cir. 1975), the district court stated:

> "It cannot be disputed that the terms boycott and coercion, as commonly defined, might be construed to encompass the type of activity attributed to defendants in the instant case. An examination of the legislative history of this section reveals, however, that Congress was seeking to regulate a rather narrow area of activity bearing no resemblance to the situation described in Plaintiffs' Complaint. Section 1013(b) was designed *primarily* to deal with conspiracies or combinations among insurance companies and agents for the purpose of boycotting or refusing to deal with other insurance companies and agents." (emphasis supplied) 372 F. Supp. at 513-514.[14]

[14] We apply emphasis to the word "primarily" because we do not believe section 1013(b) should be strictly limited to the classic situation of insurance company blacklisting. In appropriate circumstances, the language of that provision would reach other practices which have the same purpose and effect as blacklisting or which are equally pernicious in violating the most fundamental notions of competition and fair play. In the instant case we are not presented with circumstances that require us to decide this issue. *But see* Addrisi *v.* Equitable Life Insurance Society, 503 F.2d 725 (9th Cir. 1974), *cert. denied*, 420 U.S. 947 (1975).

Frankford Hospital's reliance on *Battle* v. *Liberty Life Insurance Company*, 493 F. 2d 39 (5th Cir. 1974), *cert. denied*, 419 U.S. 1110 (1975), is misplaced. In that case the plaintiff was challenging activities of an insurance company (involving an arrangement with an additional party) that had *nothing to do with the issuing of insurance*. The court held that the McCarran-Ferguson Act exemption did not apply to the instant complaint. It explicitly distinguished *Travelers Insurance Company* v. *Blue Cross, supra*. In *dictum*, the court stated that even if the McCarran-Ferguson Act applied, the complaint would survive a motion to dismiss, because of allegations that brought Section 1013(b) into play. The complaint alleged, *inter alia*, that the defendants threatened to build funeral homes to compete with the plaintiffs' businesses; threatened physical violence against the plaintiffs and their agents; and threatened to cancel insurance contracts. Frankford Hospital has not alleged threats of physical violence, or threats to build competing hospitals, by Blue Cross. Furthermore, it is undisputed that Blue Cross as not threatened to cancel any contracts but rather has continuously offered to enter into the 1971 and 1974 uniform cost contracts with plaintiffs.[15]

[15] We note, however, that Frankford Hospital contends that Blue Cross has used its existing contractual relationships with the hospitals by intentionally withholding large sums of money which it owes to the hospitals in order to coerce them into signing a new contract.

Frankford Hospital asserts that the provisions in Blue Cross subscriber contracts which set the rates of reimbursement for services received from non-member hospitals are "coercive." The district and the circuit court considered virtually the identical argument in *Travelers, supra,* and reached the conclusion:

> "[T]he economic inducements which made the Blue Cross contract acceptable to hospitals did not amount to 'coercion'." (footnote omitted) 481 F. 2d at 84.[16]

In *Doctors Hospital* v. *Blue Cross of Greater Philadelphia, supra,* the court rejected the plaintiff's claim that Blue Cross committed an act of boycott, coercion or intimidation by placing an advertisement in a newspaper which informed the public of the date at which Doctors Hospital would no longer be a Blue Cross member hospital. After certain DVHC hospitals became non-member hospitals on or about September 1, 1974, Blue Cross took steps to notify its subscribers of the names of those hospitals which were continuing to provide member benefits to all subscribers. These steps included the running of newspaper notices. Copies of these advertisements are in the record.[17] None of them is any more coercive to non-member

[16] The omitted footnote in the above quoted passage stated, "If a hospital refused to agree to the contract, Blue Cross would reimburse the hospital on a per diem basis at an amount insufficient to cover the hospital's costs. A hospital would have to make up any deficiency by charging the patients directly. We note that this procedure is typical of the indemnification plans offered by private insurance companies."

[17] Exhibit P, Q and U to Affidavit of Bruce Taylor.

hospitals than the inoffensive advertisement considered in *Doctors Hospital.* Even without this precedent, we would have to conclude that these notices were not only non-coercive within the meaning of section 1013(b) but that it was a responsible business decision to communicate to subscribers the information contained therein.

We will now discuss the allegations of plaintiff which do not have direct corollaries in *Travelers* and *Doctors Hospital.* First, we consider plaintiff's attempt to give a factual basis to its boycott theory. Assuming *arguendo,* that the term, boycott, in section 1013(b) extends to boycotts of persons other than insurance companies and insurance agents,[18] Frankford Hospital still has not created a triable issue of material fact as to its allegation that Blue Cross has conspired with others or otherwise conducted a boycott of non-member hospitals. Frankford Hospital contends that the defendant's main boycott device is its subscriber contracts, which provide that subscribers who are treated in non-member hospitals receive indemnity from Blue Cross in amounts less than the full charges for those services. The argument is that the differential diverts Blue Cross subscribers away from member hospitals and therefore by contracting with hospitals for services Blue Cross is boycotting all hospitals with which it does not contract. Plaintiff also alleges that the defendant has fueled the boycott by running newspaper advertisements that urge sub-

[18] *But see,* Meicler, *supra,* and Addrisi, *supra.*

scribers (and, incidently, the general public) to stay away from non-member hospitals, and by conspiring with union officials to exort union member subscribers from patronizing non-member hospitals. As discussed above *Travelers and Doctors Hospital* have disposed of any notion that the terms of Blue Cross indemnity agreements in subscriber contracts and/or newspaper advertisements which Blue Cross has run constitute prohibited boycotts. As to the allegation of a Blue Cross-union conspiracy, Frankford Hospital has to rest much of its argument on a leaflet issued by Local 834 of the United Auto Workers which stated, *inter alia,*

> "[A]gain, we ask you, if at all possible please stay out of the non-participating hospitals."

There is no evidence that Blue Cross either had prior knowledge that this statement would be made or that it encouraged or counseled the making of such a statement. The uncontradicted depositions of Francis J. McGuire, President, United Automobile Workers Local No. 834, and of Cecil V. Mullen, President, International Brotherhood of Electrical Workers Local Union No. 1241, make clear that the leaders of these locals acted at their own initiative to try to protect their members from suffering unexpected financial hardships as a result of going to non-member hospitals. They sought information from Blue Cross in order to advise their members; Blue Cross repesentatives gave them basic information about coverage under the particular union contracts. On one occasion, a Blue

Cross representative said that a subscriber who is treated in a non-member hospital could anticipate being asked to pay his or her bill before checking out. Mr. Mullen volunteered the information that a protest letter he wrote to non-member hospitals contained mistaken assertions. He had made some hasty conclusions based on what he was told by the Blue Cross representative, and based on unreliable information from other sources.[19] Similarly, the comments Mr. McGuire addressed to union members (and are objected to by Frankford Hospital) were based on his own ideas and information.[20]

In conclusion, each of the alleged elements of the "boycott" lacks a factual or a legal basis, if not both.

Second, Frankford Hospital alleges that Blue Cross has failed to negotiate with the hospitals in good faith. We fail to see how this allegation, even if true, would

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[19] The following exchange in the Mullen deposition illustrates the small role played by Blue Cross representatives:

> "By Mr. Bogus [plaintiff's counsel]: Mr. Mullen, did you have occasion to discuss this matter with any one else at Blue Cross other than Mr. Gannon?
>
> Mr. Mullen: No, I have a very hard time getting anyone at Blue Cross to talk to me." Deposition p. 14.

[20] "Mr. Bogus: Did anyone at Blue Cross tell you that non-participating hospitals were likely to harrass or pester your members? [Objected to by Blue Cross counsel]

Mr. McGuire: No. The hospitals have did it, though. The hospitals have did it. They have harrassed and pestered our members.
Q: Have you discussed that problem with anyone at Blue Cross?
A: To the point where, you know what's happening, has there been anything done through negotiations or stuff like that." McGuire Deposition p. 9.

activate section 1013(b). Even if we assume that Blue Cross has been able to adhere to unreasonable negotiating positions because of its dominance in the health insurance market, that would take the plaintiff no further than stating an element of a cause of action under the Sherman Act. But the Sherman Act is irrelevant until plaintiff can carry its burden of showing that the McCarran-Ferguson Act does not apply, and the allegation of bad faith negotiations does not prove that point. In any event, we do not think the plaintiff has established a triable question of fact on the good faith of Blue Cross negotiations in the face of the approval by the Insurance Department of the 1971 and 1974 agreements, and in the face of the Commonwealth's enactment of Act 94. Moreover, the participation of the insurance department in the negotiation of hospital contracts is unabated and so long as this active regulation continues it is the province of the commissioner to rule on the good faith or bad faith of the negotiating parties.[21]

There are some remaining allegations of coercion. Plaintiff says Blue Cross has withheld information from non-member hospitals about the benefits that Blue Cross subscriber patients are entitled to; that Blue Cross has refused to honor assignments of benefit agreements which would entitle non-member hospitals to be paid directly by Blue Cross; that Blue Cross has refused to adjust interim rates of reimbursements to hospitals, as required by existing contract;

[21] See *supra*, at p. 7, [pagination in manuscript opinion]

and that Blue Cross has otherwise "systematically ignored and abused clear legal rights of the hospitals." At least two of these alleged actions are the subject matter of state court contract actions and a third has resulted in a settlement. Even if these grievances could support causes of action under state law, and even if they might be unreasonable restraints of trade if that question were ever reached under section 1 and 2 of the Sherman Act, they do not have any bearing on the McCarran-Ferguson Act exception, 15 U.S.C. § 1013(b).

We conclude that judgment must be entered for the defendant on the antitrust claims alleged in the complaint. The subject of this action is the business of insurance and it is being aggressively regulated by the Commonwealth of Pennsylvania. The plaintiff has failed to make a preliminary factual showing that it might, at trial, prove that this case comes under the exception to the McCarran-Ferguson Act's general exemption of regulated insurance activities from antitrust scrutiny. Furthermore, because judgment will be entered against plaintiff on its federal claims (which conferred jurisdiction on this court) prior to trial, we decline to exercise pendent jurisdiction over its state law claims. *United Mine Worker* v. *Gibbs,* 383 U.S. 715, 726 (1966).[22]

CLARENCE C. NEWCOMER, *J.*

[22] In declining to exercise pendent jurisdiction we have also considered that it is extremely unlikely that we would ever decide the

(footnote continued on following page)

merits of the state law claims in plaintiff's favor. Only a novel state law argument could defeat the otherwise obvious conclusion that Pennsylvania common law doctrines of unfair competition have been preempted by the statutes establishing non-profit hospital plans and providing for their regulation; and by Act 94. However, before we would base a decision on a novel state law claim we would abstain so that that decision could be made, if at all, in the state courts. Thus, had we exercised pendent jurisdiction the best result the plaintiff could have expected would have been for the court to abstain. Thus it is made no worse off by our failure to exercise pendent jurisdiction.

Exhibit B

[Letterhead of
SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102]

July 8, 1975

Honorable William A. Shephard
Insurance Commissioner
Insurance Department
Finance Building—Room 108
Harrisburg, PA. 17120

Dear Commissioner Shephard:

At our meeting on July 3, 1975, Governor Shapp asked us to put in writing what we consider to be the remaining issues and to state our position on each of them.

DVHC believes the remaining issue are as follows:

1. *Unreimbursed Patient Care and Operating Growth Need*

We will accept annually 7½% based on the total Blue Cross reimbursable costs of Provider which shall be paid to the Delaware Valley Hospital Council and distributed by it among the Providers.

2. *Areawide Planning of Health Care Facilities*

Provider shall comply with PL 92-603 § 1122 and applicable sections of PL 93-641 when implemented.

[Letterhead of
SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102]

We do not object to the "B" Agency, or whatever agency is empowered under the law contracting with the Hospital Survey Committee to perform functions required by law. However, only the final decisions made by the planning agency designated by law will be binding on the parties.

3. *Term of Agreement*

We will agree to a firm two (2) year contract terminating on June 30, 1977, with neither party having the right to terminate the agreement during the two (2) year period. However, we will not agree to any run-out period after June 30, 1977.

4. *Retroactivity*

We believe that any agreement has to be retroactive to July 1, 1974.

During the retroactive period Providers will be reimbursed their total Blue Cross reimbursable costs based generally on the 1971 Agreement as modified by the 1973 Agreement of Principles and recent negotiations, and with no ceilings or Medicare cost limitations of any kind.

We would agree to your suggestion to give Blue Cross credit for money paid to Subscribers where

[Letterhead of
SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102]

Blue Cross has paid non-member benefits on a per diem basis, but if Blue Cross has paid full charges to a patient, we will not give Blue Cross credit for the amount in excess of reimbursable cost. Providers will actively pursue collection procedure against those patients who did not pay Provider the money received from Blue Cross.

We believe that we have reached agreement on the other items. However, we cannot be sure until we attempt to put the other items into contract form.

Sincerely yours,

/S/ FRANK H. ABBOTT
Frank H. Abbott, Attorney
for Delaware Valley
Hospital Council

Exhibit C

[Letterhead of Blue Cross of Greater Philadelphia]

August 20, 1975

TO: CHIEF EXECUTIVE OFFICERS OF THE DVHC REPRESENTED HOSPITALS

Dear Sir:

Today the plaintiffs in *Guest, et al.* v. *Fitzpatrick, et al.*, Civil Action No. 75-2306, withdrew their request to have the United States District Court for the Eastern District of Pennsylvania enjoin the use by Blue Cross of the payment procedures described in my letter of August 5, 1975 (an additional copy of our letter of August 5, 1975 is enclosed for your convenience). Accordingly, since it is necessary that Blue Cross not be exposed to the obligation to make duplicate payments to the Provider and Subscriber for the same Covered Services, checks will continue to be issued with a restrictive endorsement.

However, it appears that there may be some misunderstanding concerning the purpose, scope and effect of the payment procedure adopted.

While Blue Cross will support the constitutionality of Act No. 94 in the pending litigation, there is no intention that the negotiation or transfer of Blue Cross checks will deprive any hospital payee of its

[Letterhead of Blue Cross of Greater Philadelphia]

right, should it desire to do so, to challenge the constitutionality of Act No. 94 generally or, once having cashed one or more Blue Cross checks with respect to certain admissions, to change its policy and refuse to accept and negotiate checks with respect to future or other admissions.

The purpose of the payment procedure is simply to eliminate the uncertainty produced by the attack on Act No. 94 by reaching a mutually-agreed settlement as to the payments to be made by Blue Cross and a subscriber to the Provider with respect to *only* those admissions covered by the particular check in question.

By negotiating or transferring a Blue Cross check which refers to this letter, the Provider will be agreeing that payment by Blue Cross under the 1971 Hospital Agreement, as amended by the 1973 Summary of Principles (the "Agreement") will be the only payment which the Provider will seek with respect to the particular admissions covered by the check in question, and that the Provider will not, *as to those particular admissions only,* make any direct claim against the subscriber not permitted by the Agreement.

We hope you will agree that this is a practical and responsible arrangement in light of the pending uncertainty over the status of Act No. 94.

[Letterhead of Blue Cross of Greater Philadelphia]

If, after reviewing the foregoing, you have any questions as to the payment procedures which Blue Cross intends to follow, please feel free to contact our officers.

Very truly yours,
/S/ HOWARD W. BAKER
Howard W. Baker, M.D.
Vice President

HWB:bts
Enclosure

Restrictive Endorsement

Front

"This check is drawn against funds on deposit with the drawee in a special account and is valid and payable by the drawee only when the form of agreement printed on the reverse side hereof has been subscribed to by the payee named hereon without any deletion or alteration whatsoever in such form."

Back

"The payee intending to be legally bound hereby agrees that by this negotiation or transfer of this instrument the payee named hereon agrees that it has accepted and will be bound by the provisions of the drawer's letter of August 6, 1975 to the payee relating to Act No. 94."

[Letterhead of Blue Cross of Greater Philadelphia]

August 21, 1975

TO: CHIEF EXECUTIVE OFFICERS OF THE DVHC REPRESENTED HOSPITALS

Dear Sir:

Under the 1971 Hospital Agreement, as amended by the 1973 Summary of Principles (the "Agreement") which has been reinstated by Act No. 94, Blue Cross is obligated to provide your hospitals with current financing (i.e., working capital advances). We desire to reinstate these advances as soon as practical, but we are faced with the uncertainty created by the pending litigation challenging the constitutionality of Act No. 94.

In the event Act No. 94 is declared unconstitutional, it will, of course, be appropriate for such advances to be returned to Blue Cross. Since in such an event Blue Cross will not be holding amounts payable to a hospital out of which to recover the advance, and since the very existence of the advance is a recognition on the part of a hospital of the need for working capital, effective provisions for repayment of these advances raises significant practical problems.

One option would be for a hospital to give Blue Cross appropriate security for prompt repayment of

[Letterhead of Blue Cross of Greater Philadelphia]

the advances, and we stand ready to discuss these arrangements on an individual basis, recognizing that Blue Cross will need to be provided with security of a quality and availability comparable to that contemplated by the Agreement under normal termination circumstances.

Recognizing that in some situations a hospital will not be in a position to offer such security, we believe that equivalent security would exist if a Provider agrees that in the event Act No. 94 is declared unconstitutional, it will thereafter voluntarily handle sufficient new admissions under the Agreement to exhaust the amount of the advance then outstanding. This is similar to the normal termination of the Agreement and should in general be fully compatible with your existing financing arrangements and restrictions.

In order to expedite payment of the advances, they are being tendered to you on the assumption that the arrangements stated in the previous paragraph are acceptable to you, and by negotiating or transferring the check or checks representing such advances you will be deemed to have agreed to such contingent repayment arrangement.

If you prefer to make other arrangements for security which is equivalent to the security which would exist under the Agreement in a case of normal termination, you should return the enclosed check, and ad-

vise us of the nature of the security which you can make available.

Very truly yours,

/S/ HOWARD W. BAKER
Howard W. Baker, M.D.
Vice President

HWB:bts
Enclosure

[FORM OF CHECK]

This check is drawn against funds on deposit with the drawee in a special account and is valid and payable by the drawee only when the form of agreement printed on the reverse side hereof has been subscribed to by the payee named hereon without any deletion or alteration whatsoever in such form.

Blue Cross
of Greater Philadelphia
1833 Chestnut Street
Philadelphia, Pennsylvania 19107

3-50
310
93809

Pay: LANKENAU HOSPITAL
LANCASTER &
CITY LINE AVENUES
PHILA., PENNA. 19151

The Fidelity Bank, Philadelphia, Pa.
Hospital Service Account
Check Number 093809
AMOUNT $327,457.00
Exactly $327,457 Dollars and 00 Cents
Date 08/21/75
Void after 60 days

[Letterhead of
SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102]

August 21, 1975

William Zeiter, Esquire
Morgan, Lewis & Bockius
123 South Broad Street
Philadelphia, PA. 19109

Re: Blue Cross letter of August 20, 1975 to
Chief Executive Officers

Dear Mr. Zeiter:

The purpose of this letter is to confirm your statement to me of today that by cashing the checks referred to in your letter, the hospitals agree not to pursue any claims against the subscribers for whom Blue Cross has made payment, and Blue Cross agrees that even if Act 94 is held to be unconstitutional Blue Cross will not claim any refund of the monies paid. Furthermore, it is understood the cashing of the checks would have no effect on retroactivity of our current negotiations.

Sincerely yours,

/S/ FRANK H. ABBOTT
Frank H. Abbott
For SCHNADER, HARRISON, SEGAL
& LEWIS

[Letterhead of
MORGAN, LEWIS & BOCKIUS
Counselors at Law
123 South Broad Street
Philadelphia, Pennsylvania 19109]

August 22, 1975

Frank H. Abbott, Esquire
Schnader, Harrison, Segal & Lewis
1719 Packard Building
Philadelphia, Pennsylvania 19102

Re: Blue Cross letter of August 20, 1975 to
Chief Executive Officers

Dear Mr. Abbott:

The first sentence of your letter of August 21, 1975 correctly summarizes the substance of our recent telephone conversation.

I am not clear as to the meaning of "retroactivity of our current negotiations" in the second sentence of your letter, but since I take it that it relates to a subject beyond the scope of the matters mentioned in the first sentence of your letter, you are correct that cashing of the subject checks would have no effect thereon.

With kindest regards,

Sincerely,

/S/ WILLIAM E. ZEITER
William E. Zeiter

sk
cc: David S. Markson, Esquire

[Letterhead of
SCHNADER, HARRISON, SEGAL & LEWIS
1719 Packard Building
Philadelphia, Pennsylvania 19102]

August 27, 1975

Mr. Bruce Taylor
Blue Cross of Greater Philadelphia
1333 Chestnut Street
Philadelphia, PA. 19107

Dear Bruce:

The purpose of this letter which is being sent on behalf of all the hospitals represented by the Delaware Valley Hospital Council in the current negotiations with Blue Cross is to inform you that the hospitals refuse to accept the terms and conditions set forth in Dr. Baker's letters of August 5, August 20 and August 21, 1975.

Act No. 94 makes no provisions for Blue Cross unilaterally making restrictions on the payments it makes to the hospitals. If anyone is to impose restrictions, it shall be the Court, by whose holding the hospitals will abide.

Accordingly, the hospitals refuse to accept or be bound by the restrictive endorsements on the checks being issued and the terms and conditions set forth in the letters. We have been instructed to inform you that on September 2, 1975 the hospitals will cash all

checks in their possession and if you insist that the restrictive endorsements are binding, it is up to you to stop payment on the checks before September 2, 1975.

With best regards,

Sincerely yours,

/S/ FRANK H. ABBOTT
Frank H. Abbott
For SCHNADER, HARRISON, SEGAL & LEWIS

August 27, 1975

Hospitals Represented by the Delaware Valley Hospital Council

Abington Memorial Hospital
All Saints Hospital
Booth Maternity Center
Bryn Mawr Hospital
Bryn Mawr Rehabilitation Center
Clement Atkinson Memorial Hospital
Crozer Chester Medical Center
Delaware County Memorial Hospital
Delaware Valley Hospital
Doylestown Hospital
Episcopal Hospital
Frankford Hospital
Germantown Dispensary & Hospital
Holy Redeemer Hospital
Jeanes Hospital
John F. Kennedy Memorial Hospital
Lankenau Hospital
Magee Memorial Hospital
Memorial Hospital, Roxborough
Mercy Catholic Medical Center
  Misericordia Division
  Fitzgerald Mercy Division
Methodist Hospital
Montgomery Hospital
Nazareth Hospital

Northeastern Hospital
Paoli Memorial Hospital
Phoenixville Hospital
Presbyterian-University of
  Pennsylvania Medical Center
Riddle Memorial Hospital
Sacred Heart Hospital, Chester
Sacred Heart Hospital, Norristown
Saint Christopher's Hospital for Children
Saint Joseph's Hospital
Suburban General Hospital
Taylor Hospital
West Park Hospital
Wills Eye Hospital

[Letterhead of Blue Cross of Greater Philadelphia]

August 27, 1975

Frank H. Abbott, Esq.
Schnader, Harrison, Segal & Lewis
1719 Packard Building
Philadelphia, Pennsylvania 19102

Dear Frank:

This will respond to your letter of August 27, 1975 (copy attached) relating to negotiation of Blue Cross checks.

As you know from your participation in proceedings before the United States District Court for the Eastern District of Pennsylvania in *Guest et al* v. *Fitzpatrick et al,* Civil Action No. 75-2306, Blue Cross is exposed to a substantial risk of duplicate payment liability if Public Act No. 94 is held invalid.

In the absence of the Act our obligation with respect to admissions in Delaware Valley Hospital Council represented institutions is solely to pay the non-member benefit to our Subscribers. Under the Act our obligation is to pay the Provider institution.

As you also know, the District Court, when considering your attack on our payment practices, made clear that Blue Cross has every right to protect the Plan against the risk of duplicate payment in the present uncertain circumstances. As a community

[Letterhead of Blue Cross of Greater Philadelphia]

agency responsible to our subscribers and the Pennsylvania Insurance Commissioner, we cannot permit large contingent liabilities for duplicate payments to accrue. Instead we have adopted procedures which permit the establishment of a definitive payment program for Providers; one which permits Blue Cross, the Subscriber and the Provider to know immediately the economic consequences of a particular admission. In view of the indefinite time which a challenge to the validity of Public Act No. 94 will doubtless consume, and the availability throughout the community of a substantial number of member hospitals whose status is unaffected by the validity or non-validity of Act No. 94, such a clarification of the status of admissions to DVHC hospitals is clearly in the public interest.

Accordingly your counteroffer, as contained in your letter of August 27, 1975 must be, and is hereby, rejected. Any negotiation or transfer of our checks bearing reference to Dr. Baker's letters of August 5, August 20, August 21 and/or August 26, 1975 will be deemed an offer by the payee hospital to accept settlement with Blue Cross on the basis set forth in the applicable provisions of Dr. Baker's above-mentioned letters. In addition, because of the mechanical problems incidental to the administration of our Hospital Service Account, we could consider any further counteroffers on behalf of a payee hospital only when

[Letterhead of Blue Cross of Greater Philadelphia]

the counteroffer is accompanied by the return uncashed to Blue Cross of the Blue Cross check or checks to which the counteroffer relates.

Yours very truly,

/S/ BRUCE TAYLOR
Bruce Taylor
President

BT:ccb

cc: CHIEF EXECUTICE OFFICERS OF THE DVHC REPRESENTED HOSPITALS

CERTIFIED MAIL
RETURN RECEIPT REQUESTED